BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **SUNGNAM JOE, M.D.** Holder of License No. **24593** For the Practice of Allopathic Medicine In the State of Arizona.	Board Case No. MD-07-0749B **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER** (Letter of Reprimand)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 4, 2008. Sungnam Joe, M.D., ("Respondent") appeared before the Board with legal counsel Thomas G. Bakker for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 24593 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-07-0749B after being notified of a malpractice settlement involving Respondent's care and treatment of a fifty-four year-old male patient ("FB") alleging that Respondent failed to obtain a urology consultation in a timely manner that led to kidney failure and subsequent death.

4. On March 13, 2003, late morning, FB went to the emergency room complaining of cramping, left flank pain and diarrhea. He expressed concern about a possible kidney stone. Laboratory tests showed an elevated BUN and creatinine and a CT scan noted a prior right nephrectomy, compensatory hypertrophy of the left kidney with a cortical stone of two to three millimeters and a possible two to three millimeter stone in the region of the distal left ureter.

5. Respondent was contacted by the emergency room nurse practitioner and advised of FB's status and the CT scan results. Respondent gave instructions for hydration and discharge. FB was given a large volume of fluids; however, a subsequent bladder scan revealed minimal urine. A catheter was placed with little urine return. IV fluid was continued at 2250 p.m.; however, FB was still unable to void after almost five liters of fluid. A second call was placed to Respondent by the nurse practitioner and a decision was made to admit FB to Respondent's care and to order a nephrology consultation. Holding orders were written by emergency room personnel that included Toradol, Demerol and Phenergan for pain. FB was admitted to the hospital at 0315 a.m. on March 14, 2003.

6. FB's condition worsened and Respondent was contacted at 0705 a.m. Respondent advised that a nephrologist be consulted as soon as possible. The nephrologist was contacted and gave a verbal order for a urology consultation. A call was placed to the urologist. Shortly thereafter, Respondent and the nephrologist saw FB. The nephrologist again recommended urologic consultation, stone analysis once retrieved and avoidance of nephrotoxins.

7. Morning labs showed significant worsening of renal function. Respondent discontinued the Toradol; however, meperidine was continued for pain. At 1140 a.m., the urologist was notified that FB still had no urine output. At 7:20 p.m., Respondent was notified that the urologist had not seen FB. The urologist finally saw FB at 2100 p.m. and ordered procedures. By the time the anesthesiologist arrived at 2100 p.m. for the indicated procedures, FB's condition had deteriorated and he subsequently died. The autopsy indicated that the most likely proximate cause of death was asphyxia secondary to acute bilateral pulmonary edema secondary to acute CHF secondary to volume overload with obstructive uropathy.

8. The standard of care in a patient with only one kidney requires that the physician directly contact and discuss the patient with a urologist when the patient begins to appear anuric.

9. Respondent deviated from the standard of care by failing to recognize acute renal failure and failing to recognize the need for urgent, direct urological consultation. FB's treatment was delayed and he died.

10. The standard of care requires that a physician discontinue medication (meperidine) that is contraindicated for a patient with renal insufficiency.

11. Respondent deviated from the standard of care by continuing medication that is contraindicated for a patient with renal insufficiency.

12. A physician is required to maintain adequate medical records. An adequate medical record means a legible record containing, at a minimum, sufficient information to identify the patient, support the diagnosis, justify the treatment, accurately document the results, indicate advice and cautionary warnings provided to the patient and provide sufficient information for another practitioner to assume continuity of the patient's care at any point in the course of treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he failed to document the telephone call in which he made contact with the urologist.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient;") A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public;").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

Respondent is issued a Letter of Reprimand for failure to obtain a urology consultation in an urgent manner, failure to discontinue medication that was contraindicated in a patient with renal insufficiency and for inadequate medical records.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 8th day of October, 2008.

ARIZONA MEDICAL BOARD 1913 STATE OF ARIZONA

THE ARIZONA MEDICAL BOARD

By _____
LISA S. WYNN
Executive Director

ORIGINAL of the foregoing filed this 8th day of October, 2008 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
7th day of October, 2008, to:

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Sungnam Joe, M.D.
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